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TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
9592  
CERTIFICATE OF DEATH

09583

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL WILLIAMSPORT RT#2</b> c. LENGTH OF STAY IN 1b <b>16 YEARS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WILLIAMSPORT ROUTE #2</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL WILLIAMSPORT RT# 2</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LYNN</b> Middle <b>RAY</b> Last <b>AMSLEY</b>		4. DATE OF DEATH Month <b>AUG</b> Day <b>3</b> Year <b>1961</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 4 1900</b>
9. AGE (In years last birthday) <b>61 yrs.</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TAVERN OPERATOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>TAVERN</b>	11. BIRTHPLACE (County & State, or foreign country) <b>FRANKLIN CTY PENNA</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JOHN AMSLEY</b>	
14. MOTHER'S MAIDEN NAME <b>JANE HEINBAUGH</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give year or dates of service)	
16. SOCIAL SECURITY NO. <b>173 - 03-0883</b>		17. INFORMANT <b>MRS. LYNN AMSLEY WILLIAMSPORT RT#2</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ac myocardial infarction</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8/3/61</b> to <b>8/3/61</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>8/3/61</b> , 19 <b>61</b> , and that death occurred at <b>6 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Ralph F. Young</b>		22b. DATE SIGNED <b>8/4/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>RALPH F. YOUNG M.D.</b>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>AUG 7 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>REST HAVEN CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN MARYLAND</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>SUTER - ROUZER</b> ADDRESS <b>HAGERSTOWN MD.</b>		25a. REC'D BY REGISTRAR <b>AUG 9 '61</b> DATE	
		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

VR A15 (4)  
15M 9/60

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*[Faint, illegible handwritten notes and signatures]*

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TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
9593 CERTIFICATE OF DEATH 09584

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Funkstown		c. LENGTH OF STAY IN 1b 20 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8 Poplar St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Etha Middle Ellen Last Angle		4. DATE OF DEATH Month 8 Day 20 Year 19 61	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 5, 1892
9. AGE (In years lost birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) home duties		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Charlton, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John E. Gruber		14. MOTHER'S MAIDEN NAME Susie A. Martin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. John Kelly		Address Funkstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterial-sclerotic heart DUE TO (c) Sudden		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Leukemia mellitus Sept 9/1960		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 9 1960 to Aug 20 1961, that (I) (we) last saw the deceased alive on Aug 20 1961, and that death occurred at 11 PM, from the causes and on the date stated above.			
22a. SIGNATURE Sidney Novenstein		22b. DATE SIGNED 8-21-61	
22c. PHYSICIAN'S NAME (Type) S. D. NOVENEIN		22d. ADDRESS FUNKSTOWN MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 8-23-61	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Margaret R. Rowland		ADDRESS Clear Spring Md.	
25a. REC'D BY REGISTRAR DATE AUG 24 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

1. PLACE OF DEATH e. COUNTY <b>WASHINGTON</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>27 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>		d. STREET ADDRESS <b>1359 SALEM AVE.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MAURICE NELSON FREED ARNSPARGER</b>		4. DATE OF DEATH <b>AUG 2 19 61</b>		5. SEX <b>MALE</b>	
6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DEC 25 1879</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CONDUCTOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RAILROAD</b>		11. BIRTHPLACE (County & State, or foreign country) <b>SABILLASVILLE MD</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JAMES ARNSPARGER</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH H EBY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT <b>MRS LAURA H FORYSTHE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>332X</b> IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO <b>332X</b> (b) <b>Cerebral Atherosclerosis</b> DUE TO <b>332X</b> (c) <b>Hypertensive Cardiovascular Disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>28 days</b> <b>4 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		21. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>July 6 1961</b> to <b>Aug. 2 1961</b> , that (I) <del>last</del> saw the deceased alive on <b>Aug 2 1961</b> , and that death occurred at <b>2:05 am</b> , from the causes and on the date stated above.	
22a. SIGNATURE <b>W. T. Layman</b>		22b. DATE SIGNED <b>8-4-61</b>		22c. PHYSICIAN'S NAME (Type) <b>WILLIAM T LAYMAN M.D.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>AUG 5 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>	
23d. LOCATION (City, town or county) <b>HAGERSTOWN MARYLAND</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles M Rouzer</b>		25a. REC'D BY REGISTRAR <b>DATE AUG 9 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>		25c. NAME OF CEMETERY OR CREMATORY <b>HAGERSTOWN MD</b>		25d. DATE <b>AUG 9 '61</b>	

MEDICAL CERTIFICATION

1955

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WASHINGTON, D.C. 20540

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
9595									
09586									
1. PLACE OF DEATH e. COUNTY <b>Washington</b> f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> g. LENGTH OF STAY IN 1b <b>Life</b> h. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>136 W. Washington St.</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> f. COUNTY <b>Washington</b> g. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> h. STREET ADDRESS <b>1703 W. Washington Street</b> i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>EDITH ELIZABETH BAKER</b>					4. DATE OF DEATH Month <b>August</b> Day <b>28</b> Year <b>1961</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 3, 1906</b>		9. AGE (In years last birthday) <b>55</b> yrs. IF UNDER 1 YEAR: Months <b>55</b> Days <b>55</b> Hours <b>55</b> Min. <b>55</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Board of Education</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Hagerstown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles S. Brewer</b>					14. MOTHER'S MAIDEN NAME <b>Ella Westman</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give year or dates of service)				16. SOCIAL SECURITY NO. <b>216-22-8656</b>		17. INFORMANT <b>Mr. Walter E. Baker</b> Address <b>Hagerstown, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary artery occlusion</b> DUE TO (b) <b>4-20-1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>2 hours.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) <b>(this hospital)</b> attended the deceased from <b>1952 to 8/28</b> , 19 <b>61</b> that (I) <b>(v)</b> last saw the deceased alive on <b>8/28</b> , 19 <b>61</b> , and that death occurred <b>10:25 A</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>George Jennings</b>				22b. DATE SIGNED <b>8/29/61</b>		22c. PHYSICIAN'S NAME (Type) <b>George Jennings</b>			
22d. ADDRESS <b>136 W. Washington St., Hagerstown</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/31/1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Hagerstown, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Suter - Rouzer Funeral Home</b> <b>A. Franklin Rouzer</b>				ADDRESS <b>Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR <b>AUG 31 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	



2532

Washington

Washington

135 W. Washington St.

WHITE

WASHINGTON

WHITE

August

1901

White

January 3, 1900

Cook

Board of Education

John Westman

Charles A. Brown

on

216-22-2255

Mr. Walter E. Westman, Washington, Maryland

*Handwritten signature*

8/28

61

8/28

Exhibit

8/21/1901

Rose Hill Cemetery

Exhibit - House - Metal Case

Washington, D.C.

Aug 21 1901

Washington, Maryland

Case 1-100



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

9596

09587

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Highfield</b>			c. LENGTH OF STAY IN 1b <b>life</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Highfield</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Harold Milton Baker</b>				4. DATE OF DEATH Month Day Year <b>August 27 19 61</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 6, 1913</b>		9. AGE (In years last birthday) <b>48</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>State Hospital</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry D. Baker</b>				14. MOTHER'S MAIDEN NAME <b>Elsie Willard</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>220 09 0019</b>		17. INFORMANT <b>Mrs. Harold M. Baker</b>		Address <b>Highfield, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>None</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8/27 1961</b> to <b>8/27 1961</b> , that (I) (we) last saw the deceased alive on <b>8-27 1961</b> , and that death occurred at <b>2:00 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>R. B. Brown</b> M.D.				22b. DATE <b>8/28/61</b>		22c. PHYSICIAN'S NAME (Type) <b>R. B. BROWN M.D.</b>	
				22d. ADDRESS <b>WAYNESBORO PA.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/30/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bethel Church of God</b>		23d. LOCATION (City, town, or county) (State) <b>Washington Co., Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Kella Y. Gore</b>				25a. REC'D BY REGISTRAR DATE <b>AUG 29 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9597

09588

<b>1. PLACE OF DEATH</b> a. COUNTY <u>WASHINGTON</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> <span style="float: right;">c. LENGTH OF STAY IN 1b <u>6 WEEKS</u></span> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>NO. 25 HIGH STREET</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> <span style="float: right;">b. COUNTY <u>WASHINGTON</u></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>03 HAGERSTOWN</u> d. STREET ADDRESS <u>1 25 HIGH ST.</u> <span style="float: right;">e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></span>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>MARY C BAKER</u>		<b>4. DATE OF DEATH</b> <u>AUGUST 25 1961</u>		5. SEX <u>FEMALE</u> <span style="float: right;">6. COLOR OR RACE <u>WHITE</u></span> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <span style="float: right;">8. DATE OF BIRTH <u>MAY 22 1874</u></span> 9. AGE (In years last birthday) <u>87</u> yrs. <span style="float: right;">10. KIND OF BUSINESS OR INDUSTRY <u>HOUSE KEEPER</u></span> 11. BIRTHPLACE (County & State, or foreign country) <u>BENEVOLA WASH. Co. MD. U.S.A.</u>			
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>JOHN CROSS</u> <span style="float: right;">14. MOTHER'S MAIDEN NAME <u>ELIZABETH MOATS</u></span>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> <span style="float: right;">16. SOCIAL SECURITY NO. <u>NONE</u></span> 17. INFORMANT <u>MRS. CERTIE LEGGETT HAGERSTOWN MD.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0 Uremia</u> Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic disease, generalized</u> (c) <u>Indefinite</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death 1 wk</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <span style="float: right;">20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)</span> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20c. TIME OF INJURY <u>19</u> <span style="float: right;">20d. INJURY OCCURRED <u>White at work</u></span> Hour a.m. <u>19</u> <span style="float: right;">20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</span> p.m. <u>19</u> <span style="float: right;">20f. (City or town) <u>HAGERSTOWN</u> (County) <u>WASHINGTON</u> (State) <u>MD.</u></span>					
21. I certify that (I) (this hospital) attended the deceased from <u>8-21-61</u> to <u>8-26-61</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>8-21-61</u> , and that death occurred at <u>12:15 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert F. Keadle</u> <span style="float: right;">22b. DATE SIGNED <u>8-28-61</u></span>		22c. PHYSICIAN'S NAME (Type) <u>ROBERT F. Keadle M.D.</u> <span style="float: right;">22d. ADDRESS <u>318 N. Potomac St., Hagerstown, Md.</u></span>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>AUG-28-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BENEVOLA CEMETERY</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Rost</u> <span style="float: right;">25a. REC'D BY REGISTRAR <u>SEP 5 '61</u></span>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>		25c. NAME OF CEMETERY OR CREMATORY <u>BENEVOLA WASH. Co. MD.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and, in any event, within 72 hours after death.

DR. KEADLE  
 318 N. Potomac St.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Pages may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9598

09589

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>38 yrs</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>870 Frederick Road</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>1870 Frederick Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>FLORENTINE L.C. BARBER</b>		4. DATE OF DEATH <b>August 1 1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 31 1867</b>
9. AGE (In years last birthday) <b>94</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Thurmont Fred. Co Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Hiram Arthur</b>	
14. MOTHER'S MAIDEN NAME <b>Nancy Heine</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Charles T. Barber</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Calculi urinary bladder</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Indefinite</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (U) (this hospital) attended the deceased from <b>July 11, 1961</b> to <b>Aug. 1, 1961</b> that (U) (we) last saw the deceased alive on <b>Aug. 1, 1961</b> and that death occurred at <b>M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>B. B. Kneisley</b> M.D.		22b. DATE SIGNED <b>8/2/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>B. B. Kneisley, M.D.</b>		22d. ADDRESS <b>148 West Washington St., Hagerstown Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8/4/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Hagerstown Wash Co Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		25a. REC'D BY REGISTRAR <b>AUG 7 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

10528

2522

(M)

(1)

Annex A. Form A. Information



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9599

09590

<b>1. PLACE OF DEATH</b> e. COUNTY <u>Washington</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hancock</u>		c. LENGTH OF STAY IN 1b <u>20 Yrs</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hancock Maryland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Home</u>				d. STREET ADDRESS <u>1</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Walter Armstrong Blackwell Jr</u>				<b>4. DATE OF DEATH</b> Month <u>8</u> Day <u>1</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>7.17.1908</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>1</u>		IF UNDER 24 HRS. Hours <u>19</u> Min. <u>61</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Concret Block MFG.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>North East Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter A Blackweell Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Elsie McCauley</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Isabel Blackwell Hancock Md.</u>			
17. INFORMANT <u>Isabel Blackwell Hancock Md.</u>				Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-11-</u> 19 <u>59</u> to <u>6-7</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>6-7</u> 19 <u>61</u> , and that death occurred at <u>9:40 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>F.B. Thomas III M.D.</u>				22b. DATE SIGNED <u>8-3-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>F.B. THOMAS III M.D.</u>				22d. ADDRESS <u>HANCOCK Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8.4.61</u>		23c. NAME OF CEMETERY OR ADDRESS <u>Presbyterian</u>		23d. LOCATION (City, town or county) (State) <u>Hancock Washington Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur L. Thomas</u>				25a. REC'D BY REGISTRAR <u>DATE AUG 7 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Pages may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60



2322

Washington, Maryland

Hammond, Maryland

June

Washington, D.C.

July 17, 1908

North East Maryland

John A. Johnson, Jr.

Hammond, Maryland

Hammond, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3600

## CERTIFICATE OF DEATH

09591

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>7 months</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Western Maryland State Hosp.</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Airy</u> d. STREET ADDRESS <u>RFD # 3</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Willie Lee Bridges</u>		<b>4. DATE OF DEATH</b> Month <u>Aug.</u> Day <u>21</u> Year <u>1961</u>	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Feb. 16, 1904</u>
<b>9. AGE</b> (In years, if UNDER 1 YEAR, last birthday) <u>57</u> yrs. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Painter</u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Troy, Ohio</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Arvlee Bridges</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Goldie Warfield</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>214-16-1485</u>	
<b>17. INFORMANT</b> <u>Ollie C. Bridges, New Market, Md.</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>myocardial infarction</u> DUE TO (b) <u>general atherosclerosis</u> DUE TO (c) <u>unknown</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</b> <u>(1) Abdominal aorta graft, thrombotic (2) multiple kidney infarction (3) Pulmonary emphysema (4) Pulmonary fibrosis</u>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>19</u> e.m. p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (1) (this hospital) attended the deceased from <u>January 27, 1961</u> to <u>Aug. 21, 1961</u>, that (1) <del>(two)</del> last saw the deceased alive on <u>Aug. 21, 1961</u>, and that death occurred at <u>6:30 PM</u>, from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Victor L. Ramos, M.D.</u>		<b>22b. DATE SIGNED</b> <u>Aug. 21, 1961</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>VICTOR L. RAMOS, M.D.</u>		<b>22d. ADDRESS</b> <u>Western Md. State Hospital Hagerstown, Maryland</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>8/23/61</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Montgomery Meth.</u>		<b>23d. LOCATION (City, town or county) (State)</b> <u>Clagetsville, Md.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Olin L. Molisworth</u>		<b>25a. REC'D BY REGISTRAR</b> <u>AUG 23 '61</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Kraus</u>		<b>25c. ADDRESS</b>	



200

Washington

Washington

Y. M. C. A.

St. Albans

Eastern Railway State Road

St. Albans

Willie Lee Higgins

Male White

Age 10, 1004

Teacher

Education

Day, Ohio

Amos Higgins

Boys' Institute

St. Albans

Office of the U. S. Marshal, St. Albans, Vt.

88

1937

1937

Washington, D. C.

Washington, D. C.

Washington, D. C.

Washington, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9601

Item 14 Film G293 8/16/61

09592

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>3 DAYS</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>WASHINGTON</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		d. STREET ADDRESS <b>364 S. CANNON AVE.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JENNIE</b>		First		Middle <b>BELL</b>		Last <b>BUSSARD</b>		4. DATE OF DEATH <b>AUG 1 1961</b>		Month		Day		Year	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 26 1894</b>		9. AGE (In years last birthday) <b>67 yrs.</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>ADAMS COUNTY PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>									
13. FATHER'S NAME <b>JAMES O BROWN</b>		14. MOTHER'S MAIDEN NAME <b>GERTRUDE Ford</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>ROSCOE C BUSSARD</b>		Address <b>HAGERSTOWN MARYLAND</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive C.V. Disease</b> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <b>July 30 1961</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <b>July 21 1961</b> to <b>Aug 1 1961</b> , that (I) (we) last saw the deceased alive on <b>Aug 1 1961</b> , and that death occurred at <b>2:00 PM</b> , from the causes and on the date stated above.															
22a. SIGNATURE <b>Sidney Novenstein</b> M.D.		22b. DATE SIGNED <b>8-1-61</b>		22c. PHYSICIAN'S NAME (Type) <b>SIDNEY NOVENSTEIN M.D.</b>		22d. ADDRESS <b>Funkhouser Rd</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>Aug 3 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>REST HAVEN CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN MARYLAND</b>									
24. FUNERAL DIRECTOR'S SIGNATURE <b>SUTER - ROUZER FUNERAL HOME</b>		ADDRESS <b>HAGERSTOWN MD.</b>		25a. REC'D BY REGISTRAR <b>AUG 9 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Kinn</b>									

VR A15 (4)  
15M 9/60

1032

1032

(M)

WASHINGTON COUNTY HOSPITAL  
J. H. SHAW  
3 DAYS  
MAY 28 1934

WHITE  
MAY 28 1934

TRANS. BY NURSING STAFF

RECEIVED  
MAY 28 1934

ROBERT S. HARRIS  
MAY 28 1934

*Robert S. Harris*  
*May 28 1934*

*Robert S. Harris*  
*May 28 1934*

RECEIVED  
MAY 28 1934

ROBERT S. HARRIS  
MAY 28 1934



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
9602  
CERTIFICATE OF DEATH  
09593

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>LIFE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>30 N. LOCUST ST.</b>		d. STREET ADDRESS <b>130 N. LOCUST ST.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARY FRANCES CLELAND</b>		4. DATE OF DEATH Month Day Year <b>AUGUST 22 1961</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/21/1905</b>
9. AGE (In years last birthday) <b>56 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <b>SCHOOL TEACHER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PUBLIC SCHOOLS MARYLAND</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EDWARD KIRBY SAUM</b>		14. MOTHER'S MAIDEN NAME <b>EK MALINDA ANDERSON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220-05-6873</b>	
17. INFORMANT Address <b>MR. WALTER W. CLELAND HAGERSTOWN MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Adeno carcinoma</b> DUE TO <b>170X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Adeno Carcinoma of rt breast</b> DUE TO <b>6 yrs.</b> (c) <b>6 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus - Arteriosclerotic Heart Disease</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from <b>June 1954</b> to <b>Aug 22 1961</b> , that (I) (we) last saw the deceased alive on <b>Aug 22 1961</b> , and that death occurred at <b>11 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Clord A. Hoffman</b>		22b. DATE SIGNED <b>Aug 23-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Clord A. Hoffman</b>		22d. ADDRESS <b>214 N. Potomac St. Hagerstown</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>8/25/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b>		23d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Norment, Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 28 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

(M)

(J)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, and 3 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

M

I

MAYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAYLAND														
CERTIFICATE OF DEATH														
9603														
09594														
1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN 1b <u>50 YRS.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WESTERN MD. STATE HOSP.</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> d. STREET ADDRESS <u>701 N. HOLBERRY ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Lily Gertrude CLOPPER</u>					4. DATE OF DEATH Month <u>8</u> Day <u>26</u> Year <u>1961</u>									
5. SEX <u>FEMALE</u>					6. COLOR OR RACE <u>WHITE</u>									
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>3/12/1883</u>									
9. AGE (In years last birthday) <u>78</u> yrs.					10. IF UNDER 1 YEAR Months Days Hours Min.									
11. USUAL OCCUPATION Give kind of work done during most of working life (even if retired) <u>HOUSEWIFE</u>					12. 10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>									
13. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>					14. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
15. FATHER'S NAME <u>WILLIAM HULSE SR.</u>					16. MOTHER'S MAIDEN NAME <u>NANCY BOWARD</u>									
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>					18. SOCIAL SECURITY NO. <u>NONE</u>									
19. INFORMANT <u>MRS. VIOLA DENORE</u>					Address <u>HAGERSTOWN MD.</u>									
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>Arteriolosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiovascular disease</u> DUE TO <u>Ten years</u> (c) <u>Diabetes mellitus. Cirrhosis of liver</u>										INTERVAL BETWEEN ONSET AND DEATH <u>one week</u> <u>Unknown</u> <u>Ten years</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus. Cirrhosis of liver</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.										20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)				
21. I certify that (I) (if hospital) attended the deceased from <u>May 1</u> , 19 <u>61</u> to <u>Aug 26</u> , 19 <u>61</u> , that (I) <u>(no)</u> last saw the deceased alive on <u>Aug 26</u> , 19 <u>61</u> , and that death occurred at <u>4:50</u> P.M. from the causes and on the date stated above.										22a. SIGNATURE <u>Young E. Chun</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>YOUNG E. CHUN</u>				
22b. DATE SIGNED <u>Aug 27, 1961</u>										22d. ADDRESS <u>1500 Penna. Ave. Hagerstown, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>										23b. DATE WHEREOF <u>8/29/61</u>				
23c. NAME OF CEMETERY OR CREMATORY <u>BRADFORDING CEM.</u>										23d. LOCATION (City, town or county) (State) <u>WASHINGTON CO., MD.</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>W.J. Norman</u>										25a. REC'D BY REGISTRAR <u>AUG 30 '61</u>				
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>														



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

9604

09595

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>4 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Western Maryland State Hospital</b>				d. STREET ADDRESS <b>10,221 Grant Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Richard</b> Middle <b>Everett</b> Last <b>COLEMAN</b>				4. DATE OF DEATH Month <b>8</b> Day <b>4</b> Year <b>1961</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 12, 1902</b>	
9. AGE (In years lost birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MECH. Mach. (Retired)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>G.B. Macke Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Montana</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>David Coleman</b>				14. MOTHER'S MAIDEN NAME <b>Adilia Cooper</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>-----</b>			
17. INFORMANT <b>Mrs. Helen M. Coleman</b>				18. CAUSE OF DEATH (Enter only one cause prevailing for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobular Pneumonia</b> DUE TO <b>Chronic brain syndrome with Psychosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>10 weeks</b> DUE TO (c) <b>10 weeks</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Neurodermatitis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 11, 1961</b> to <b>Aug 4, 1961</b> , that (I) (we) last saw the deceased alive on <b>Aug 4, 1961</b> , and that death occurred at <b>A. M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Young E. Chun</b>				22b. DATE SIGNED <b>Aug 4, 1961</b>		22c. PHYSICIAN'S NAME (Type) <b>YOUNG E. CHUN</b>	
22d. ADDRESS <b>1500 Penna. Ave Hagerstown, Md</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/7/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. John's Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Forest Glen, Montgomery, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Pumphrey, Inc. 8434 Georgia Avenue</b>				25. REC'D BY REGISTRAR <b>Raymond A. Ziska</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



CERTIFICATE OF DEATH

1904



Washington

Place of Birth

Age

Sex

Married or Single

Richard Everett Coleman

Place of Death

Time

Date

Cause of Death

Medical History

Attending Physician

Medical Examiner

Signature of Physician

Signature of Examiner

John F. Coleman

Remains to be

April 11, 1904

Age 21

Sex Male

Place of Birth

Place of Death

Time

Date

Signature of Physician

Signature of Examiner



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9605

## CERTIFICATE OF DEATH

Reg. Dist. No. 09596

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sandy Hook</u>		LENGTH OF STAY (in this place) <u>4 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Knoxville</u>		<u>10X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Clark Road</u>				STREET ADDRESS (If rural give location) <u>Cemetery Road</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>LACY MAHALIA COOPER</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Aug. 10, 1961</u>			
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Married</u>	<b>8. DATE OF BIRTH</b> <u>June 30, 1895</u>	<b>9. AGE last birthday</b> <u>66</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own Home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Knoxville, Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>John William King</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Laura Katy Fauble</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>212-24-5674</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Chester O. Cooper</u> <u>Knoxville, Maryland</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>31X IMMEDIATE CAUSE (A)</b> <u>Myocardial infarction</u>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>4 days</u>			
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> DUE TO (C)							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>8-1-61</u>, to <u>8-10-61</u>, that I last saw the deceased alive on <u>8-10-61</u>, 19<u>61</u>, and that death occurred at <u>1:40A</u> M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>[Signature]</u> M.D.				<b>ADDRESS</b> (Street, city, town, state) <u>[Address]</u>		<b>DATE SIGNED</b> <u>8-17-61</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>8/12/61</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Reformed Cemetery</u>		<b>LOCATION (City, town, or county) (State)</b> <u>Knoxville, Maryland</u>	
<b>24. REG'D BY REGISTRAR</b> <u>Aug 22 61</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>[Signature]</u>		<b>ADDRESS</b> <u>Harper's Ferry West Va.</u>	

20/01/2001 10:01:11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 should be retained by the attending physician and completed immediately in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9606

CERTIFICATE OF DEATH

09597

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Boonsboro</b>				c. LENGTH OF STAY IN 1b <b>8 yrs.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Farnhey-Keedy Mem. Home</b>				d. STREET ADDRESS <b>Boonsboro</b>			
3. NAME OF DECEASED (Type or print) <b>MRS. CLARA K. DUVALL</b>				4. DATE OF DEATH <b>August 8, 1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 28, 1870</b>	
9. AGE (in years last birthday) <b>91 yrs.</b>		IF UNDER 1 YEAR <b>8</b> Months <b>8</b> Days		IF UNDER 24 HRS. <b>1961</b> Hours <b>8</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>E. Frederick Klein</b>				14. MOTHER'S MAIDEN NAME <b>Mary M. Jacobs</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>Mr. Russell Klein, Mt. Airy, Maryland</b>			
17. INFORMANT <b>Mr. Russell Klein, Mt. Airy, Maryland</b>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO <b>Coronary arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>4 weeks</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 10, 1961</b> to <b>Aug 8, 1961</b> , that (I) (we) last saw the deceased alive on <b>Aug 8, 1961</b> , and that death occurred at <b>7 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>G. W. LeVan</b>				M.D. <b>G. W. LeVan</b>		22b. DATE SIGNED <b>8/8/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>G. W. LeVan</b>				22d. ADDRESS <b>Boonsboro, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8-11-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Frederick Co., Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz, Winfield, Maryland</b>				25a. REC'D BY REGISTRAR <b>AUG 10 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

VR A15 (4)  
15M 9/60

(M)

2092

Washington

Marine

6 yrs.

Boys

Army-Johnson

Mr. Clark

Mr. Clark

Female

Feb. 1, 1890

Domestic

Domestic

A. Frederick

Mr. W. Johnson

Mr. W. Johnson

Mr. W. Johnson

Mr. W. Johnson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

M

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
9607									
09598									
1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>11 Wks.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Western Md. State Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Williamsport Md.</u> d. STREET ADDRESS <u>Boonsboro Rd. Williamsport Md.</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>OLIVE LOUISE EBERSOLE</u>					4. DATE OF DEATH Month <u>Aug.</u> Day <u>9</u> Year <u>1961</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12.17.16</u>		9. AGE (In years last birthday) <u>44</u> yrs. <u>4</u> UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nursing</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>			11. BIRTHPLACE (County & State, or foreign country) <u>State Line Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clyde Binkley</u>					14. MOTHER'S MAIDEN NAME <u>Jessie Greenwalt</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Jack M Ebersole</u> Address <u>Md Boonsboro Rd. Williamsport</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>generalized carcinoma tosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>carcinoma of the ovaries</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>June 26, 1961</u> to <u>Aug. 9, 1961</u> , that (I) (we) last saw the deceased alive on <u>Aug. 9, 1961</u> , and that death occurred at <u>9:35</u> AM, from the causes and on the date stated above.									
22a. SIGNATURE <u>Victor L. Ramos, M.D.</u>					22b. DATE SIGNED <u>Aug. 9, 1961</u>				
22c. PHYSICIAN'S NAME (Type) <u>VICTOR L. RAMOS, M.D.</u>					22d. ADDRESS <u>Western Maryland State Hospital Hagerstown, Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>8.12.61</u>		23c. NAME OF CEMETERY OR <u>Greenlawn</u>		23d. LOCATION (City, town or county) (State) <u>Williamsport Washington Md.</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Howard F. Stone</u> ADDRESS <u>Hancock Md</u>					25a. REC'D BY REGISTRAR <u>AUG 15 1961</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>		

14

5082

Washington

Washington

Washington, State Hospital

11 Dec. 1917

Washington, State Hospital

F

X

12.17.16

14

Washington

Washington

State Line Farm

U.S.A.

(Type Birkley)

State Line Farm

Back M. Female Washington, D.C.

12.17.16

Washington, State Hospital

Washington, State Hospital



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page may be retained by hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN lb <b>18 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>236 Farragut St. N. W.</b> d. STREET ADDRESS <b>236 Farragut St. N. W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Francis E. Erickson</b>						4. DATE OF DEATH Month <b>August</b> Day <b>11</b> Year <b>19 61</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 16, 1885</b>		9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lawyer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Internal Rev.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Fall Brook Pa.</b>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Fredrick Erickson</b>						14. MOTHER'S MAIDEN NAME <b>Johanna Palmgren</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>--</b>				16. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT Address <b>Mrs. Marjorie B. Erickson Wash. D.C.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Reticulum cell sarcoma, retroperitoneal, with liver metastasis</b> 200.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Thrombosis, portal vein, secondary to (1)</b>										INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>July 24, 19 61</b>		20g. (County) <b>August 11, 19 61</b>		20h. (State) <b>2:37 A.M.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>July 24, 19 61</b> to <b>August 11, 19 61</b> , that (I) (we) last saw the deceased alive on <b>August 10, 19 61</b> , and that death occurred at <b>2:37 A.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>John H. Kehne</b> 22c. PHYSICIAN'S NAME (Type) <b>John H. Kehne M.D.</b>						22b. DATE <b>August 11, 19 61</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>131 W. Washington St. Hagerstown, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8-15-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Maple Grove</b>		23d. LOCATION (City, town or county) (State) <b>Hoosick Falls N. Y.</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>						ADDRESS <b>Hagerstown, md.</b>		25a. REC'D BY REGISTRAR <b>AUG 15 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Huns</b>	

M

2003

OFFICE OF DEATH

1903

John A. Thompson

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9609

## CERTIFICATE OF DEATH

Reg. Dist. No. 119600

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>W. Va.</u> b. COUNTY <u>Hampshire</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>7 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hosp</u>		d. STREET ADDRESS <u>—</u>	
3. NAME OF DECEASED (Type or print) First <u>VIRGINIA</u> Middle <u>CATHERINE</u> Last <u>EVANS</u>		4. DATE OF DEATH Month <u>8</u> Day <u>12</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-11-07</u>
9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>— — Sirk</u>		14. MOTHER'S MAIDEN NAME <u>—</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hospital records</u>		Address <u>Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>WIDE SPREAD Metastatic CANCER</u> DUE TO (b) <u>Carcinoma of uterus</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>4 mo</u> <u>4 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug 5, 1961</u> , to <u>Aug 12, 1961</u> , that I last saw the deceased alive on <u>Aug 12, 1961</u> , and that death occurred at <u>5:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Shirley R. Tuttle</u> M.D.		ADDRESS (Street, city or town, state) <u>302 N. Potomac St</u> DATE SIGNED <u>8-12-61</u>	
PHYSICIAN'S NAME (Type) <u>Hagerstown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-15-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Luke Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Romney, W. Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich &amp; Son, Hagerstown, Md</u>		24a. REC'D BY REGISTRAR <u>AUG 15 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Christ S. Thoms</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1968

DEPARTMENT OF HEALTH BALTIMORE		COUNTY OF <u>Washington</u>	
NAME OF DECEASED <u>John Doe</u>		SEX <u>Male</u>	
DATE OF BIRTH <u>10-15-1925</u>		PLACE OF BIRTH <u>Washington, D.C.</u>	
DATE OF DEATH <u>11-10-1968</u>		PLACE OF DEATH <u>Home</u>	
TIME OF DEATH <u>10:00 AM</u>		CAUSE OF DEATH <u>Heart Disease</u>	
MANNER OF DEATH <u>Natural</u>		SIGNATURE OF PHYSICIAN <u>[Signature]</u>	
SIGNATURE OF DECEASED <u>[Signature]</u>		SIGNATURE OF WITNESS <u>[Signature]</u>	
SIGNATURE OF NEXT OF KIN <u>[Signature]</u>		SIGNATURE OF CORONER <u>[Signature]</u>	
SIGNATURE OF REGISTRAR <u>[Signature]</u>		SIGNATURE OF CLERK <u>[Signature]</u>	

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

X

(I)

MEDICAL CERTIFICATION

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BP

1  
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9610

CERTIFICATE OF DEATH

09601

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>37 Yrs</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>122 So Potomac St</b>			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>122 So Potomac St</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>EMMA GRACE FAHRNEY</b>			4. DATE OF DEATH <b>August 23 1961 19</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>January 12 1878</b>		9. AGE (In years last birthday) <b>83 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Hagerstown Wash Co Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Christian Fridinger</b>			
14. MOTHER'S MAIDEN NAME <b>Eliza Brnde</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No --</b>	
16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT <b>Harman F. Full 409 Linganore Ave</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Insufficiency</b> <b>420.1</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Hypertensive Cardiovascular Disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 Minutes</b> <b>10 days</b> <b>13 years</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) ( <del>we</del> ) attended the deceased from <b>Aug. 14 11:15 am</b> to <b>Aug. 23 1961</b> , that (I) (we) last saw the deceased alive on <b>Aug. 20 1961</b> , and that death occurred at <b>11:15 am</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>William T. Layman, M.D.</b>		22b. DATE SIGNED <b>Aug 29 1961</b>		22c. PHYSICIAN'S NAME (Type) <b>William T. Layman, M.D.</b>	
22d. ADDRESS <b>100 Professional Arts Bldg. Hagerstown, Maryland</b>		22e. ADDRESS <b>100 Professional Arts Bldg. Hagerstown, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/26/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	
23d. LOCATION (City, town or county) <b>Hagerstown Wash Co Md.</b>		23e. LOCATION (State) <b>Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>		24a. ADDRESS <b>Hagerstown Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	
24c. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		24d. ADDRESS <b>Hagerstown Md.</b>		24e. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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Andrew A. Goldman

William E. Goldman

100 West 11th Street  
New York, N.Y.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9611											
09602											
1. PLACE OF DEATH a. COUNTY Washington						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Md. b. COUNTY Wash.					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown					
c. LENGTH OF STAY IN 1b 5 days						d. STREET ADDRESS 114 E. Baltimore St.					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Western Maryland State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Nettie FAHRNEY						4. DATE OF DEATH Month Day Year 8 2 1961					
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 30, 1869		9. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Leitersburg, Md.		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME Daniel Lowman						14. MOTHER'S MAIDEN NAME no first name Summers					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Robert J. Fahrney, Hagerstown, Md.					
18. CAUSE OF DEATH [Enter only one cause, no line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular Pneumonia 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cerebrovascular accident (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 6 days one month											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 28, 1961 to Aug 2, 1961, that (I) (we) last saw the deceased alive on Aug 2, 1961, and that death occurred at 3:25 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Young E. Chun M.D.						22b. DATE SIGNED Aug 2, 1961					
22c. PHYSICIAN'S NAME (Type) YOUNG E. CHUN						22d. ADDRESS 1500 Penna. Ave. Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial				23b. DATE THEREOF 8-5-61		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) Hagerstown, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.						25a. REC'D BY REGISTRAR DATE AUG 7 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

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Smithson & Son, Hagerstown, Md.

Smithson & Son, Hagerstown, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page may be retained by hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY (in 1b) <b>1 Week</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Western Maryland State Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Gilmore, R.F.D., Lonaconing</b> d. STREET ADDRESS <b>01X-2</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Hazel</b> Middle <b>mae</b> Last <b>Fazzenbaker</b>					4. DATE OF DEATH Month <b>Aug.</b> Day <b>18</b> Year <b>1961</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/15/1911</b>		9. AGE (In years last birthday) <b>50</b> yrs. IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> IF UNDER 24 HRS.: Hours <b>0</b> Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Frostburg, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		
13. FATHER'S NAME <b>Albert Stott</b>					14. MOTHER'S MAIDEN NAME <b>Nellie Stott</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>(If yes give number or date of service)</b>		17. INFORMANT <b>David Hobell Barton, MD.</b> Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>uremia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>carcinoma of cervix</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>10 mos.</b>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 10, 1961</b> to <b>Aug. 18, 1961</b> , that (I) (we) last saw the deceased alive on <b>Aug. 10, 1961</b> , and that death occurred at <b>6 PM</b> , from the causes and on the date stated above.										
22a. SIGNATURE <b>Victor L. Ramos, M.D.</b>					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>Aug. 18, 1961</b>			
22c. PHYSICIAN'S NAME (Type) <b>VICTOR L. RAMOS, M.D.</b>					22d. ADDRESS <b>Western Maryland State Hospital Hagerstown, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/21/1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Lonaconing, MD.</b>				
24. FUNERAL DIRECTOR'S SIGNATURE <b>GEORGE EICHHORN</b>					ADDRESS <b>LONACONING, MD.</b>		25a. REC'D BY REGISTRAR <b>AUG 21 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Krause</b>	

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8/27/54 Oak Hill Cemetery

GEORGE EICHHORN      BOARDING

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MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

03604

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boonsboro</b>				c. LENGTH OF STAY IN 1b <b>3 Years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Reeder Nursing Home</b>				d. STREET ADDRESS <b>612 Middle Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>VIRGINIA</b> Last <b>GORDON</b>				4. DATE OF DEATH Month <b>August</b> Day <b>13</b> Year <b>19 61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 4, 1885</b>	
9. AGE (In years lost birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Companion</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Charles Herbert Prince</b>				14. MOTHER'S MAIDEN NAME <b>Mary Ann Brown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>220-34-1183</b>		17. INFORMANT Address <b>Mrs. Emma E. Young, R.F.D.#4, Frederick, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X</b> DUE TO <b>Hypertensive cardio vascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>July 10, 1961</b> to <b>Aug 13, 1961</b> , that (I) (we) last saw the deceased alive on <b>Aug 12, 1961</b> , and that death occurred at <b>12:00 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>G. W. Helvan</b>				22b. DATE SIGNED <b>8/13/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>G. W. Helvan</b>				22d. ADDRESS <b>Boonsboro</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug. 16, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pleasant View Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Frederick County, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				25a. RECEIVED BY REGISTRAR <b>Aug 18 1961</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur J. ...</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH																			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
9614																			
CERTIFICATE OF DEATH																			
09605																			
1. PLACE OF DEATH a. COUNTY Washington					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington														
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown														
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>														
3. NAME OF DECEASED (Type or print) Guy Miller Grove					4. DATE OF DEATH August 31 1961														
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 27, 1886		9. AGE (In years last birthday) 75 yrs.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plummer		10b. KIND OF BUSINESS OR INDUSTRY Plumbing		11. BIRTHPLACE (County & State, or foreign country) near Clearspring, Md.		12. CITIZEN OF WHAT COUNTRY?		IF UNDER 1 YEAR Months Days Hours Min.											
13. FATHER'S NAME George M. Grove					14. MOTHER'S MAIDEN NAME Martha Unknown														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 217-32-5145					17. INFORMANT Miss Ada Nae Dougherty Hag. Md.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 446X Uremia DUE TO Nephrosclerosis DUE TO Generalized Arteriosclerosis DUE TO Arteriosclerotic Heart Disease & failure PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 wk 2-3 yr 10 yr										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 1959, 12, to 8/31, 1961, that (I) (we) last saw the deceased alive on 8/31, 1961, and that death occurred at 4:30 P.M. from the causes and on the date stated above.										22a. SIGNATURE Robert Vh Campbell		22b. ADDRESS 145 W Washington ST. HAGERSTOWN Md		22c. PHYSICIAN'S NAME (Type) Robert Vh. Campbell		22d. ADDRESS 145 W Washington ST. HAGERSTOWN Md		22e. DATE SIGNED 9/1/61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 9-3-61					23c. NAME OF CEMETERY OR CREMATORY St. Pauls Cemetery					23d. LOCATION (City, town or county) (State) Near Clearspring, Md.				
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son					ADDRESS Hagerstown, md.					25a. REC'D BY REGISTRAR SEP 6 '61					25b. REGISTRAR'S SIGNATURE Arthur S. Kraus				

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Scott F. Hinton & Son, Lagarto, Ind.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon covers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

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09606

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>1 Week</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Wash County Hospital</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>17 Clinton Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>GLADSTONE EVERETT GRUBBS</b>			4. DATE OF DEATH Month Day Year <b>August 10 1961 19</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>January 16 1907</b>		9. AGE (In years last birthday) <b>54 yrs.</b>		IF UNDER 1 YEAR Months Days <b>54</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fireman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fairchild Air Co</b>		11. BIRTHPLACE (County & State, or Foreign country) <b>Winchester Frederick Co</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Lawrence D. Grubbs</b>			
14. MOTHER'S MAIDEN NAME <b>Bessie Yost</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>577-10-1413</b>		17. INFORMANT Address <b>Mrs Margaret F. Grubbs 17 Clinton Ave</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriolar nephrosclerosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Hypertensive vascular disease</b> DUE TO (c) <b>Coronary atherosclerosis with infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b> <b>3 yr.</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>19</b>		20g. (County) <b>19</b>		20h. (State) <b>19</b>	
21. I certify that (I) (the hospital) attended the deceased from <b>July 19</b> , 19 <b>60</b> to <b>Aug 10</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Aug 10</b> , 19 <b>61</b> , and that death occurred at <b>7 A.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Lloyd A. Hoffman</b> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>8/11/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lloyd A. Hoffman</b>		22d. ADDRESS <b>214 N. Potomac St. Hagerstown, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/13/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt Carmel Cemetery</b>	
23d. LOCATION (City, town or county) <b>Middletown Fred. Co Va.</b>		23e. (State) <b>19</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		ADDRESS <b>Hagerstown Md.</b>		25a. REC'D BY REGISTRAR <b>AUG 14 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kane</b>					

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*(Faint bleed-through from the reverse side of the page)*

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VR A1S (4)  
ISM 9/59

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FOR STATE  
HEALTH DEPT.

This certificate should be executed within 24 hours after death. If necessary, a deputy medical examiner may be designated by the medical examiner. Pages 1, 2, and 3 to this form are necessary, and 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

3617  
MAY 1961  
STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND		b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEITERSBURG		c. LENGTH OF STAY IN 1b LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEITERSBURG	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) LEITERSBURG MD.		d. STREET ADDRESS LEITERSBURG		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ARTHUR JOHN HARTLE		4. DATE OF DEATH AUGUST - 6 - 1961		Month Day Year	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH MAY 19 - 1896	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days 2 17
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY HOUSE BUILDER		11. BIRTHPLACE (State or foreign country) LEITERSBURG WASH. Co. MD.	
13. FATHER'S NAME JOHN C. HARTLE		12. CITIZEN OF WHAT COUNTRY? U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO		16. SOCIAL SECURITY NO. 214-09-8199		17. INFORMANT FLORENCE L. ECKSTINE Address 212 N. CANNON AVE HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.4 Coronary atherosclerosis, severe DUE TO Occlusion, right coronary Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO Cardiac hypertrophy cause test.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. TIME OF INJURY Hour e.m. p.m. 19		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. (City or town) HAGERSTOWN		20f. (County) WASHINGTON	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE E. W. Ditto, Jr., M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7/7/61	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF AUG. 9, 1961		22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY	
22d. LOCATION (City, town, or country) HAGERSTOWN WASH. Co. MD.		22e. REC'D BY REGISTRAR AUG 11 '61		22f. REGISTRAR'S SIGNATURE Arthur S. Kline	
23. FUNERAL DIRECTOR John W. Baer		ADDRESS BOONSBORO MD			

MEDICAL CERTIFICATION

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W. B. L. L.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

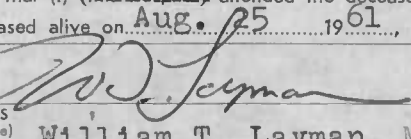
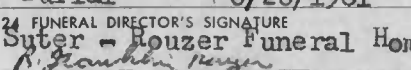
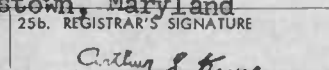
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VR A15 (4)  
ISM 9/60

<div> <div>1</div> <div> <div>MD</div> <div>9618</div> </div> <div> <div>081</div> <div>I</div> </div> </div> <div> <div> <div> <div>1</div> <div>MD</div> </div> <div> <div>9618</div> </div> </div> <div> <div>081</div> <div>I</div> </div> </div> <div> <div> <div> <div>1</div> <div>MD</div> </div> <div> <div>9618</div> </div> </div> <div> <div>081</div> <div>I</div> </div> </div> <th colspan="12"> <div> <div> <div> <div>1</div> <div>MD</div> </div> <div> <div>9618</div> </div> </div> <div> <div>081</div> <div>I</div> </div> </div> <div> <div> <div> <div>1</div> <div>MD</div> </div> <div> <div>9618</div> </div> </div> <div> <div>081</div> <div>I</div> </div> </div> </th>												<div> <div> <div> <div>1</div> <div>MD</div> </div> <div> <div>9618</div> </div> </div> <div> <div>081</div> <div>I</div> </div> </div> <div> <div> <div> <div>1</div> <div>MD</div> </div> <div> <div>9618</div> </div> </div> <div> <div>081</div> <div>I</div> </div> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>40 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington County Hospital</b>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>1060 Dual Place</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>BERTHENA</b> Middle <b>LUCINDA</b> Last <b>HENNEBERGER</b>						<b>4. DATE OF DEATH</b> Month <b>August</b> Day <b>26</b> Year <b>19 61</b>																	
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>October 15, 1907</b>		<b>9. AGE</b> (In years last birthday) <b>53</b> rs.           IF UNDER 1 YEAR Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.													
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Magnolia, W. Virginia</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>															
<b>13. FATHER'S NAME</b> <b>William F. Dyche</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Margaret Robinette</b>																	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b> (If yes give year or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <b>214-09-8152</b>		<b>17. INFORMANT</b> Address <b>Mr. Frank B. Henneberger Hagerstown, Md.</b>																	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Metastases</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Scirrhus Carcinoma of Breast</b> DUE TO (c) <b>(Post-operative)</b>										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>15 weeks</b> <b>10 months</b>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Hypertensive Cardiovascular Disease; Hemiplegia</b>																							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)																			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>													
<b>21. I certify that (I) (EXAMINER) attended the deceased from May 7, 1961, to Aug. 26, 1961, that (I) (EXAMINER) saw the deceased alive on Aug. 25, 1961, and that death occurred at 2:50 a.m. from the causes and on the date stated above.</b>																							
<b>22a. SIGNATURE</b>  <b>22c. PHYSICIAN'S NAME (Type)</b> <b>William T. Layman, M.D.</b>						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>8-26-61</b>		<b>22d. ADDRESS</b> <b>100 Professional Arts Bldg. Hagerstown, Maryland</b>													
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>8/28/1961</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Cedar Lawn Memorial Garden Hagerstown, Maryland</b>		<b>23d. LOCATION (City, town or county) (State)</b>																	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b>  <b>Suter - Rouzer Funeral Home Hagerstown, Md.</b>						<b>25a. REC'D BY REGISTRAR</b> <b>AUG 30 '61</b>		<b>25b. REGISTRAR'S SIGNATURE</b> 															

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1937

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Washington

Washington

Washington

Admission

10 years

Admission

Washington County Hospital

1000 Day Place

SEATTLE

SEATTLE

Admission

Admission

Female

White

10

October 12, 1937

Married

Married

William E. Smith

Married

no

21-0-112

Frank B. Hennepin, M.D.

General Hospital

10 years

Admission

(1937-1938)

Excessive Cardiovascular disease

SEATTLE

SEATTLE

Admission

Admission

8/28/1937

Admission

Admission

Admission

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

9619

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

09610

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>1 DAY</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL SMITHSBURG</b>		d. STREET ADDRESS <b>RT. #2 SMITHSBURG</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HENRY</b> Middle <b>STANLEY</b> Last <b>HORNBAKER</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>30</b> Year <b>19 61</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/25/1898</b>
9. AGE (In years last birthday) <b>62</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Junk Dealer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN BUSINESS</b>	
11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SIMON JOHN HORNBAKER</b>		14. MOTHER'S MAIDEN NAME <b>SARAH CATHERINE BOWMAN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name, rank, and dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>160-16-9893</b>	
17. INFORMANT <b>MR. RAY F. HORNBAKER</b>		Address <b>RT. #8 HANCOCK MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarct</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>7 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 19 59</b> to <b>Aug 30 19 61</b> , that (I) (we) last saw the deceased alive on <b>August 1 19 61</b> , and that death occurred at <b>1 P. M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Heckman</b>		22b. DATE SIGNED <b>8/31/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOSEPH SECONDARI</b>		22d. ADDRESS <b>500 NS BORO Md</b>	
23a. BURIAL, CREMATION, or other disposal (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>9/2/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b>		23d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Herment</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 5 '61</b>	
ADDRESS <b>Hagerstown Md.</b>		25b. REGISTRAR'S SIGNATURE <b>C. L. S. H. H.</b>	

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DEPARTMENT OF HEALTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>27 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>						d. STREET ADDRESS <b>135 W. Fredrick St.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>TREVA</b> Middle <b>LANDIS</b> Last <b>HOSE</b>						4. DATE OF DEATH Month <b>August</b> Day <b>26</b> , Year <b>19 61</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <b>March 3, 1936</b>		9. AGE (In years last birthday) <b>25</b> yrs.		IF UNDER 1 YEAR Months <b>25</b> Days <b>25</b> Hours <b>25</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own HHome</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Hagerstown Wash Co Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John C. Landis</b>						14. MOTHER'S MAIDEN NAME <b>Margaret Strite</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>214-34-9870</b>		17. INFORMANT Address <b>Williamsport, Maryland.</b> <b>Harry H. Hose 25 W. Fredrick St.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RETROPERITONEAL (Extensive) ABSCESS (Toxic)</b> DUE TO (b) <b>SUBDIAPHRAGMATIC ABSCESS</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) <b>ACUTE PANCREATITIS WITH Cyst Formation and FAT NECROSIS</b>										INTERVAL BETWEEN ONSET AND DEATH <b>1961-8/26/61</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>58 &gt; 1</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. <b>19</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 22</b> , 19 <b>61</b> , to <b>Aug 26</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Aug 26</b> , 19 <b>61</b> , and that death occurred at <b>2:10 P.</b> M., from the causes and on the date stated above.											
22a. SIGNATURE <b>B.B. Kneisley</b>						M.D. <b>B.B. KNEISLEY, M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>8/28/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>B.B. KNEISLEY, M.D.</b>						22d. ADDRESS <b>148 W. Wash St. Hagerstown Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/29/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Lawn Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Williamsport, Maryland.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>						ADDRESS <b>Hagerstown, Maryland</b>		25a. REC'D BY REGISTRAR <b>AUG 30 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Knapp</b>	

4372

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9621											
09612											
1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>22 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>26 Laurel Street</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>26 Laurel Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>DR. IRA LUTHER HOUGHTON</b>						4. DATE OF DEATH Month <b>August</b> Day <b>28</b> Year <b>19 61</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 25, 1895</b>		9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Medical doctor</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ira Holdon Houghton</b>						14. MOTHER'S MAIDEN NAME <b>Louise Ringwald</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>W.W. I 213-40-6751</b>		17. INFORMANT <b>Mrs. Alice Stearns Houghton Hagerstown, Md</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Arterio-sclerotic heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from <b>1961</b> to <b>Aug 28</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>21 Aug</b> , 19 <b>61</b> , and that death occurred at <b>9:30 AM</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Elden S Houghlon</b> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>8/28/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Elden S Houghlon</b>						22d. ADDRESS <b>Hagerstown Md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/1/1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Confederate Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Fredericksburg Virginia</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Suter Rouzer Funeral Home</b> <b>R. Hamilton Berger</b>						ADDRESS <b>Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR <b>AUG 31 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

14

1891

DATE OF BIRTH

1891

Washington

Washington

Washington

26 April 1891

26 April 1891

1891

1891

1891

1891

1891

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1891

Medical doctor

Medical doctor

The Nelson Hospital

The Nelson Hospital

1891-1891

1891-1891

1891

Confederate Cemetery

Confederate Cemetery

Robert - former funeral home  
Havre, Mont.

Robert - former funeral home  
Havre, Mont.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

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FOR STATE  
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9622 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09613

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>20 Years</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>907 Hamilton Blvd.</b>				d. STREET ADDRESS <b>907 Hamilton Blvd.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>AUSTIN</b> Middle <b>WERKING</b> Last <b>HOWARD</b>				4. DATE OF DEATH Month <b>August</b> Day <b>25</b> Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4 Jan 1904</b>	
9. AGE (In years last birthday) <b>57</b> yrs.		IF UNDER 1 YEAR Months <b>57</b> Days <b>57</b>		IF UNDER 24 HRS. Hours <b>57</b> Min. <b>57</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self-employed Accountant &amp; Tax Service</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>			
11. BIRTHPLACE (State or foreign country) <b>USA</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Lyndon Howard</b>				14. MOTHER'S MAIDEN NAME <b>Ella Werking</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>214-10-2019</b>			
17. INFORMANT <b>Mrs. Ruth R. Howard (Same as item #1)</b>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO 420-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>General Atherosclerosis</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b> <b>Recent</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>J. E. W. Ditto, Jr.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Dr. E. W. Ditto, Jr.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <b>8-25-61</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>8-28-61</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>				22d. LOCATION (City, town, or country) (State) <b>Frederick, Maryland</b>			
23. FUNERAL DIRECTOR <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR <b>AUG 29 '61</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>							

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50-5526



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9623

## CERTIFICATE OF DEATH

09614

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>10 Days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Oscar</u> Middle <u>Oswald</u> Last <u>Joy</u>		4. DATE OF DEATH Month <u>8</u> Day <u>11</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1.13.1908</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Auto Mechanic</u>	9. AGE (In years less birthday) <u>53</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Allegany County Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Arlington Joy</u>		14. MOTHER'S MAIDEN NAME <u>Cora Miller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. 17. INFORMANT Address <u>Jessie H Joy 55 Elizabeth St. Hagerstown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Retroperitoneal hemorrhage recurrent</u> 4-51X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Rupture abdominal aortic aneurysm</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>10 days</u> <u>10 days</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>10 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7-28-</u> <u>1961</u> to <u>8-11-</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>8-11-</u> <u>1961</u> , and that death occurred at <u>5:43 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>John H. Kehne, M.D.</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>John H. Kehne, M.D.</u>		22d. ADDRESS <u>131 W. Washington Street Hagerstown, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8.15.61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Piney Plains Methodist</u>	23d. LOCATION (City, town or county) (State) <u>Little Orleans Allegany Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Howard F. Hume</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 17 '61</u>	
ADDRESS <u>Hannock Md</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Knepp</u>	

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Washington County Hospital

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Auto mechanic

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5:45 P.M.

8-11-01

John H. Keene, M.D.

John H. Keene, M.D.

John H. Keene, M.D.

John H. Keene, M.D.

John H. Keene, M.D.

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9624

CERTIFICATE OF DEATH

08615

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>62 W. Bethel St.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Md.</b> d. STREET ADDRESS <b>62 W. Bethel St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARJORIE CORDELLA KEETS</b>		4. DATE OF DEATH Month <b>August</b> Day <b>12</b> Year <b>1961</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 28, 1890</b>	9. AGE (In years last birthday) <b>71</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>private family</b>		11. BIRTHPLACE (State or foreign country) <b>Greeneastle ra.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>John W. Agren</b>		14. MOTHER'S MAIDEN NAME <b>Matilda wright</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>220-30-9125</b>		17. INFORMANT <b>Miss Cary Banks Hagerstown md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerotic atherosclerosis. Coronary. Artery</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) DUE TO (c) DUE TO					INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 7/25</b> to <b>Aug. 12</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>7/25</b> 19 <b>61</b> , and that death occurred at <b>5:15</b> M, from the causes and on the date stated above.					
22a. SIGNATURE <b>Philip J. Hirshman</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>8/14/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D.</b>		22d. ADDRESS <b>159 W. Washington St. Hagerstown, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/15/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John R. Watson Jr.</b>		ADDRESS <b>Hagerstown Md.</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 22 1961</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kinner</b>	

NO. 113, P. 1, 1901

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9625  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

09616

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Franklin</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>4 Months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>RT #3</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Hetba</u> First <u>Harry</u> Middle <u>Benjamin</u> Last <u>Kelbaugh</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>31</u> Year <u>19 61</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 10, 1912</u>	
9. AGE (In years lost birthday) <u>48</u> yrs.		IF UNDER 1 YEAR Months <u>48</u> Days <u>0</u> Hours <u>0</u> Min.		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Body &amp; Fender Mechanic.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Pondsville, Md.</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Edward Kelbaugh</u>				14. MOTHER'S MAIDEN NAME <u>Katy Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>214-09-2800</u>		17. INFORMANT Address <u>Mrs. Harry B. Kelbaugh, Waynesboro Pa., #3</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobular Pneumonia</u> 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute Pyelonephritis; Generalized Carcinomatosis</u> DUE TO (c) <u>origin undetermined</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Pyelonephritis; Generalized Carcinomatosis</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 8, 1961</u> , to <u>Aug 31, 1961</u> , that (I) (we) last saw the deceased alive on <u>Aug 31, 19 61</u> , and that death occurred at <u>1:00 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Edson B. Moody</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Sept 4, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edson B. Moody, M.D.</u>				22d. ADDRESS <u>145 So. Prospect Street Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/3/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>		23d. LOCATION (City, town, or county) (State) <u>Waynesboro, Franklin Co., Pa.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Y. Grove</u>				ADDRESS <u>Waynesboro Pa.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 5 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>W. Y. Grove</u>			

CERTIFICATE OF DEATH

2852

1910

Name of Deceased		Date of Birth	
Sex		Age	
Place of Birth		Date of Death	
Cause of Death		Place of Death	
Occupation		Signature of Physician	
Signature of Registrar		Date of Registration	





1  
FOR STATE  
HEALTH DEPT.

This certificate should be executed within 24 hours after death. It is necessary, in certain cases, to file a copy of this certificate with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

<p>1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b></p> <p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b></p> <p>c. LENGTH OF STAY IN 1b <b>4 months</b></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1307 The Terrace</b></p>												<p>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b></p> <p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b></p> <p>d. STREET ADDRESS <b>1307 The Terrace</b></p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>																							
<p>3. NAME OF DECEASED (Type or print) First <b>HOWARD</b> Middle <b>MELVIN</b> Last <b>KICKERT</b></p>												<p>4. DATE OF DEATH Month <b>August</b> Day <b>19</b> Year <b>1961</b></p>																							
<p>5. SEX <b>male</b></p>				<p>6. COLOR OR RACE <b>white</b></p>				<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>				<p>8. DATE OF BIRTH <b>March 12, 1924</b></p>				<p>9. AGE (In years last birthday) <b>37</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.</p>																			
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales Representative Aircraft Company</b></p>								<p>10b. KIND OF BUSINESS OR INDUSTRY <b>South Holland, Ill.</b></p>								<p>11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b></p>																			
<p>13. FATHER'S NAME <b>Henry Kickert</b></p>												<p>14. MOTHER'S MAIDEN NAME <b>Elizabeth Eenigenburg</b></p>																							
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>W.W.II</b></p>												<p>16. SOCIAL SECURITY NO. <b>350-12-7675</b></p>												<p>17. INFORMANT Address <b>Mrs. Anna Kickert Hagerstown, Maryland</b></p>											
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>																								<p>INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b></p>											
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p>												<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>																							
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b></p>								<p>20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/></p>				<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>				<p>20f. (City or town) (County) (State)</p>																			
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>. Inspection <input checked="" type="checkbox"/>. Inquiry <input type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>. Accident <input type="checkbox"/>. Suicide <input type="checkbox"/>. Homicide <input type="checkbox"/>. Undetermined manner <input type="checkbox"/></p>																																			
<p>ACTUAL SIGNATURE <b>Dr. E. W. Ditto, Jr.</b></p>												<p>CHIEF MEDICAL EXAMINER <input type="checkbox"/></p>																							
<p>EXAMINER'S NAME (Type) <b>Dr. E. W. Ditto, Jr.</b></p>												<p>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></p>																							
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b></p>												<p>22b. DATE THEREOF <b>8/24/1961</b></p>				<p>22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b></p>				<p>22d. LOCATION (City, town, or country) (State) <b>Arlington, Va.</b></p>															
<p>23. FUNERAL DIRECTOR ADDRESS <b>Suter - Rouzer Funeral Home Hagerstown, Md.</b></p>												<p>24a. REC'D BY REGISTRAR <b>AUG 24 '61</b></p>				<p>24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b></p>																			

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09618

1. PLACE OF DEATH

a. COUNTY

**Washington**

**MARYLAND**

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

**Hagerstown**

c. LENGTH OF STAY IN 1b

**4 months**

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

**1307 The Terrace**

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

**Maryland**

b. COUNTY

**Washington**

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

**03 Hagerstown**

d. STREET ADDRESS

**1307 The Terrace**

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

First

**HOWARD**

Middle

**MELVIN**

Last

**KICKERT**

4. DATE OF DEATH

Month

**August**

Day

**19**

Year

**1961**

5. SEX

**male**

6. COLOR OR RACE

**white**

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

**March 12, 1924**

9. AGE (In years last birthday)

**37** yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**Sales Representative Aircraft Company**

10b. KIND OF BUSINESS OR INDUSTRY

**South Holland, Ill.**

11. BIRTHPLACE (State or foreign country)

**U.S.A.**

12. CITIZEN OF WHAT COUNTRY?

**U.S.A.**

13. FATHER'S NAME

**Henry Kickert**

14. MOTHER'S MAIDEN NAME

**Elizabeth Eenigenburg**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

**Yes**

**W.W.II**

16. SOCIAL SECURITY NO.

**350-12-7675**

17. INFORMANT

**Mrs. Anna Kickert**

Address

**Hagerstown, Maryland**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

**Coronary Occlusion**

DUE TO

**420.1**  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

**Instant**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m. p.m. **19**

20d. INJURY OCCURRED While ☐ Not While ☐ at work ☐ at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐. Inspection ☒. Inquiry ☐, and in my opinion death resulted from: Natural causes ☒. Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐

ACTUAL SIGNATURE

**Dr. E. W. Ditto, Jr.**

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

**8-22-61**

22a. BURIAL, CREMATION, REMOVAL (Specify)

**Burial**

22b. DATE THEREOF

**8/24/1961**

22c. NAME OF CEMETERY OR CREMATORY

**Arlington National Cem.**

22d. LOCATION (City, town, or country)

**Arlington, Va.**

**Va.**

23. FUNERAL DIRECTOR

ADDRESS

**Suter - Rouzer Funeral Home Hagerstown, Md.**

24a. REC'D BY REGISTRAR

**AUG 24 '61**

24b. REGISTRAR'S SIGNATURE

**Arthur S. Frank**

M

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1. Name

2. Address

3. Date of Birth

4. Sex

5. Race

6. Height

7. Weight

8. Education

9. Occupation

10. Marital Status

11. Previous Occupations

12-13-8

14. Date of Interview

15. Name of Interviewer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

9627

09617

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>40 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown R2</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>W. Md. State Hospital</b>				d. STREET ADDRESS <b>Downsville Pike</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Samuel Luther McLucas</b>				4. DATE OF DEATH <b>Aug. 12, 1961</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-15-1886</b>	
9. AGE (In years last birthday) <b>75 yrs.</b>		10. UNDER 1 YEAR Months <b>7</b> Days <b>12</b> Hours <b>12</b> Min.		11. BIRTHPLACE (County & State, or foreign country) <b>Wash. Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cabinet maker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Statton Furniture</b>			
13. FATHER'S NAME <b>Thomas Jefferson McLucas</b>				14. MOTHER'S MAIDEN NAME <b>Mary Alice Shoemaker</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-09-6912</b>		17. INFORMANT <b>Ralph R. McLucas</b> Address <b>Hagerstown, Md. Route 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>chronic myelogenous leukemia</b> <b>204.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH <b>9 mos.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 5, 1961</b> , to <b>Aug. 12, 1961</b> , that (I) (we) last saw the deceased alive on <b>Aug. 12, 1961</b> , and that death occurred at <b>11:30 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Victor L. Ramos, M.D.</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>Aug 13, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>VICTOR L. RAMOS, M.D.</b>				22d. ADDRESS <b>Western Maryland State Hospital, Hagerstown, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>8-15-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Stone Bridge Brethren</b>		23d. LOCATION (City, town or county) (State) <b>Millstone Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Margaret Rowland</b> Address <b>Clear Spring, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>AUG 15 '61</b>		25b. REGISTRAR'S SIGNATURE <b>William S. Kline</b>	

MEDICAL CERTIFICATION



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West Virginia  
Rear L Meyers

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Revised 10/10/51  
Washington D.C.  
10/10/51



Page 4  
TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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9629

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

09620

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>7 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Gateway convalescent Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Flora</b> Middle <b>Ann</b> Last <b>Miller</b>				4. DATE OF DEATH Month <b>Aug.</b> Day <b>24,</b> Year <b>1961</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 7, 1857</b>	
9. AGE (In years lost birthday) <b>10 1/4 yrs.</b>		10. UNDER 1 YEAR Months <b>10</b> Days <b>4</b> Hours <b>15</b> Min.		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <b>William Anderson</b>				14. MOTHER'S MAIDEN NAME <b>Christina Miner</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Margy Stouffer</b> Address <b>Hagerstown #5, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Vascular Disease</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Senility</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>1-1-1959</b> to <b>8-24-1961</b> that (I) (we) last saw the deceased alive on <b>8-8-1961</b> , and that death occurred at <b>3 P. M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Dr. D. R. Brewer</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type) <b>Dr. E. W. Dittler</b> 22d. ADDRESS <b>Hagerstown, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/27/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Leitersburg Lutheran</b>		23d. LOCATION (City, town, or county) (State) <b>Leitersburg Washington Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Kate Z. Grove</b> ADDRESS <b>Haynesboro, Pa.</b>				25a. REC'D BY REGISTRAR DATE <b>AUG 29 '61</b>		25b. REGISTRAR'S SIGNATURE <b>C. L. H. H. H.</b>	

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 08-11-2010 BY 60322 UCBAW

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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1. PLACE OF DEATH a. COUNTY <b>Washington</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>1223 Suters Ave</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>1 Hr</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MEREDITH WILSON MILLER Sr</b>		4. DATE OF DEATH <b>August 24 1961 19</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 28 1919</b>
9. AGE (In years last birthday) <b>41 yrs.</b>		10. IF UNDER 1 YEAR Months <b>00</b> Days <b>00</b> Hours <b>00</b> Mln. <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Service Station Attendant</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Berkeley Springs W. Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Carl Miller</b>	
14. MOTHER'S MAIDEN NAME <b>Nannie Pearl Carruthers</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>232-01-8864</b>		17. INFORMANT <b>John C. Thompson 617 No Prospect St</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) (c) <b>Cornary Artery Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8/19</b> to <b>8/24</b> , that (I) (we) last saw the deceased alive on <b>8/19</b> , and that death occurred at <b>12:00</b> PM, from the causes and on the date stated above.		22a. SIGNATURE <b>Philip J. Hirshman, M.D.</b>	
22b. PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D.</b>		22c. ADDRESS <b>159 W. Washington St. Hagerstown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/27/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Methodist Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Berkeley Springs W. Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>		25a. REC'D BY REGISTRAR <b>AUG 29 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>		25c. DATE <b>AUG 29 '61</b>	

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Washington, D.C.

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Andrew E. Collins Haverhill

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9631 CERTIFICATE OF DEATH 09622											
1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>2 weeks</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Western Md. State Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cavetown</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>CLARA</b>			First Middle Last <b>PAYNE</b>			4. DATE OF DEATH <b>AUGUST 5</b>			Month Day Year <b>19 61</b>		
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 11, 1862</b>		9. AGE (In years last birthday) <b>99</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>Wolfsville, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>David Cline</b>				14. MOTHER'S MAIDEN NAME <b>Charlotte Warrenfeltz</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. Arthur Bachtell, Cavetown, Md.</b> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LOBULAR PNEUMONIA</b> DUE TO <b>ARTERIOSCLEROTIC HEART DISEASE</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <b>420.0</b> (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO <b>ARTERIOSCLEROTIC HEART DISEASE</b> (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b>										INTERVAL BETWEEN ONSET AND DEATH <b>4 DAYS</b> <b>YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>7-24-1961</b> to <b>8-5-1961</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>8-5-1961</b> , and that death occurred at <b>2:30 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Antonio U. Pallagrosi</b> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <b>ANTONIO U. PALLAGROSI</b>						22d. ADDRESS <b>1500 Pa Ave HAGERSTOWN MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>8-8-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Cemetery</b>		23d. LOCATION (City, town or county) <b>Smithsburg, Md.</b> (State)					
24. FUNERAL DIRECTOR'S SIGNATURE <b>scott f. minnich &amp; son, Hagerstown, Md.</b> ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			
DATE <b>Aug 8 '61</b>											

15 OCTOBER 2003

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## 3.4.1. Overview

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David Childs

10. The following information is for your information:

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Scott E. Lammiman & Son, Lagerstown, Mo.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH																			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
9632 CERTIFICATE OF DEATH 09623																			
1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Md.</b> c. LENGTH OF STAY IN 1b <b>60yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>300 N. Jonathan Street</b>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Maryland.</b> d. STREET ADDRESS <b>300 N. Jonathan Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <b>Charles</b>				First <b>Charles</b>				Middle <b>Perkins</b>				Last <b>Perkins</b>							
5. SEX <b>male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Mar 18 1874</b>		9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR Months Days <b>8 28</b>		IF UNDER 24 HRS. Hours Min. <b>19 61</b>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>Kearneysville, w.Va.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>							
13. FATHER'S NAME <b>George Perkins</b>						14. MOTHER'S MAIDEN NAME <b>Anna Jackson</b>													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>				17. INFORMANT <b>Mrs Mammie Edward</b>				Address <b>141 W. Church St</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>606X</b> IMMEDIATE CAUSE (a) <b>Coronary Artery Disease</b> DUE TO <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <b>Atherosclerosis of Bloodvessels</b> (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>years -</b> <b>years.</b> <b>years.</b>																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)																			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 5 1961</b> to <b>Aug 20 1961</b> , that (I) (we) last saw the deceased alive on <b>Aug 20 1961</b> , and that death occurred at <b>6:30 P.M.</b> from the causes and on the date stated above.																			
22a. SIGNATURE <b>Philip J. Hirshman</b>						22b. DATE SIGNED <b>8/20/61</b>													
22c. PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D.</b>						22d. ADDRESS <b>159 W. Washington St. Hagerstown, Maryland</b>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>Sept 1 1961</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Hagerstown Md</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <b>John R. Watson Jr.</b>						ADDRESS <b>Hagerstown Md.</b>						25a. REC'D BY REGISTRAR <b>SEP 5 '61</b>				25b. REGISTRAR'S SIGNATURE <b>William L. Hines</b>			

3232

Washington

Maryland

Washington

Washington, D.C.

Govt.

Department of Justice

300 N. Jackson Street

300 N. Jackson Street

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Leavenworth, Kas.

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TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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9633  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

09624

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>SIX WEEKS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boonsboro</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WESTERN MARYLAND STATE HOSPITAL</u>				d. STREET ADDRESS <u>8. MAIN ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sadie Florence Reeder</u>				4. DATE OF DEATH Month Day Year <u>Aug 17, 1961</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 30 1895</u>	
9. AGE (In years lost birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>2 17</u>		IF UNDER 24 HRS. <u>2 17</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE KEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>NEAR BOONSBORO WASH. CO. MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES HUTZELL</u>				14. MOTHER'S MAIDEN NAME <u>SALLIE TOME</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>CHARLES HUTZELL</u> Address <u>ST. PAUL ST. BOONSBORO MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LOBULAR PNEUMONIA</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>ABDOMINAL CARCINOMATOSIS</u> DUE TO (c) <u>CARCINOMA OF THE HEAD OF PANCREAS</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u> <u>INDEFINITE</u> <u>INDEFINITE</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>LIVER METASTASIS</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 30, 1961</u> to <u>Aug 17, 1961</u> , that (I) (we) last saw the deceased alive on <u>Aug 17, 1961</u> , and that death occurred at <u>9:15</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Victor L. Ramos</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>Aug 17, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Victor L. Ramos, M.D.</u>				22d. ADDRESS <u>Western Maryland State Hospital Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>AUG. 19, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT. ZION CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>LOCUST GROVE WASH. CO. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. East</u>				ADDRESS <u>Boonsboro MD.</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 21 '61</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

(M)

CERTIFICATE OF DEATH

1913

NAME OF DECEASED

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

DATE OF BIRTH

SEX

COLOUR

PLACE OF BIRTH

EDUCATION

RELIGION

PROFESSION

CHARACTER OF DEATH

NO.

NAME OF PHYSICIAN

NAME OF SURGEON

NAME OF MIDWIFE

NAME OF NURSE

NAME OF ATTENDING PHYSICIAN

NAME OF ATTENDING SURGEON

NAME OF ATTENDING MIDWIFE

NAME OF ATTENDING NURSE

ATTEST: I AM A MEMBER OF THE BOARD OF HEALTH OF THE CITY OF BOSTON

AND I HAVE SIGNED THIS CERTIFICATE OF DEATH

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

9634

09625

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			c. LENGTH OF STAY IN 1b <b>1 week</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL- Pinesburg</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				d. STREET ADDRESS <b>Williamsport R.FD. #2</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>DANIEL</b>		First Middle Last <b>IRA ROTH</b>		4. DATE OF DEATH Month Day Year <b>August 11 1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 16, 1877</b>	
9. AGE (In years last birthday) <b>83</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming-Owner</b>		11. BIRTHPLACE (State or foreign country) <b>Washington Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Abraham Roth</b>				14. MOTHER'S MAIDEN NAME <b>Amanda Grosh</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-38-8661</b>		17. INFORMANT <b>Miss Helen Roth Williamsport, Md. RFD #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS WITH EMBOLISM</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>ARTERIOSCLEROSIS, GENERALIZED</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 weeks</b> <b>unknown</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <b>Archib Robert Cohen</b> attended the deceased from <b>July 8, 1961</b> to <b>August 11, 1961</b> , that (I) (we) last saw the deceased alive on <b>August 11, 1961</b> , and that death occurred at <b>5:20 AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <i>Archie Robert Cohen</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>08/11/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Archie Robert Cohen, M.D.</b>				22d. ADDRESS <b>Clear Spring, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug. 13, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Broadfording Cemetery Broadfording, Md.</b>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Albert L. Leaf</i>				ADDRESS <b>Williamsport, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 15 '61</b>	
						25b. REGISTRAR'S SIGNATURE <i>Arthur S. Harris</i>	

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CERTIFICATE OF DEATH

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Washington County Hospital I week

Washington County Hospital

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White X November 15, 1932

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9635

CERTIFICATE OF DEATH

09626

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Smithsburg	
c. LENGTH OF STAY IN 1b 1 1/2 yr.		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Western Maryland State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEORGE Alfred SCHULL		4. DATE OF DEATH Aug. 9 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 22, 1886
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		11. BIRTHPLACE (County & State, or foreign country) Washington Co., Maryland	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Cyrus B. Schull		14. MOTHER'S MAIDEN NAME Mary Cornell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Edward H. Schull		Address Smithsburg #1, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBULAR PNEUMONIA 163X DUE TO (b) CARCINOMA OF LUNGS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 4 Days 9 MONTHS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 11-30 1959 to 8-9-1961, that (I) (the) last saw the deceased alive on 8-9-1961, and that death occurred at 8:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Antonio U. Pallagrosi M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) ANTONIO U. PALLAGROSI		22d. ADDRESS 1500 Pa Ave Hagerstown Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/12/61	
23c. NAME OF CEMETERY OR CREMATORY Welty's Cemetery		23d. LOCATION (City, town or county) (State) Washington Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Walter J. Guore		25a. REC'D BY REGISTRAR DATE AUG 11 '61	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE	

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

9635

09627

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) <b>RURAL HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>6 YRS.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>GATEWAY NURSING HOME</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ELLIS EUGENE SHADRACH</b>				4. DATE OF DEATH <b>AUGUST 27 19 61</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/18/1913</b>	
9. AGE (In years lost birthday) <b>48 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NIGHT WATCHMAN</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>AUTO DEALER</b>			
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>JACOB GUY SHADRACH</b>				14. MOTHER'S MAIDEN NAME <b>ROSE SMITH</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>220-10-1164HA</b>			
17. INFORMANT <b>MRS. BETTIE HYSSONG</b>				Address <b>RT.#5 HAGERSTOWN</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Muscular Dystrophy</b> 744.01 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20d. INJURY OCCURRED							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>1955</b> 19 to <b>Aug 27, 1961</b> that (I) (we) last saw the deceased alive on <b>Aug 26, 1961</b> , and that death occurred at <b>11</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>David R. Brewer M.D.</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>8/29/61</b>							
22c. PHYSICIAN'S NAME (Type) <b>David R. Brewer</b> 22d. ADDRESS <b>Clear Springs Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>							
23b. DATE THEREOF <b>8/30/61</b>							
23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b>							
23d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Norman, Hagerstown, Md.</b> ADDRESS							
25a. REC'D BY REGISTRAR <b>SEP 5 '61</b> DATE							
25b. REGISTRAR'S SIGNATURE <b>C. J. ...</b>							

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9637

## CERTIFICATE OF DEATH

09628

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Washington</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>6 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington County Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>819 Washington Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Arthur</b> Middle <b>Marcus</b> Last <b>Sloan</b>		<b>4. DATE OF DEATH</b> Month <b>August</b> Day <b>13</b> Year <b>19 61</b>	
<b>5. SEX</b> <b>male</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>October 11, 1901</b>
<b>9. AGE</b> (In years last birthday) <b>59 yrs.</b>		<b>10. IF UNDER 1 YEAR</b> Months <b>5</b> Days <b>13</b>	<b>11. IF UNDER 24 HRS.</b> Hours <b>13</b> Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>guard</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>U.S. Capitol</b>	<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Eudora, Miss</b>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		<b>13. FATHER'S NAME</b> <b>Martin Sloan</b>	
<b>14. MOTHER'S MAIDEN NAME</b> <b>Narcisus Carter</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>yes</b> <b>WW I</b>	
<b>16. SOCIAL SECURITY NO.</b> <b>none</b>		<b>17. INFORMANT</b> <b>Mrs. Mary Sloan, Hagerstown, Md.</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary artery disease</b> DUE TO <b>Coronary artery disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Circulation - Liver</b> DUE TO <b>Heart failure</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>gastroenteritis</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>min</b> <b>yo.</b> <b>yo.</b>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>Oct 13, 1958</b> <b>to</b> <b>Aug 13, 1961</b> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>Aug 13, 1961</b> , and that death occurred at <b>12:45 PM</b> from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>Louis G. Graff</b> M.D.		<b>22b. DATE SIGNED</b> <b>Aug 17 '61</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Louis G. GRAFF</b>		<b>22d. ADDRESS</b> <b>119 E. Antietam St</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>burial</b>		<b>23b. DATE THEREOF</b> <b>8-17-61</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Rose Hill Cemetery</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Hagerstown, Md.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Scott F. Minnich &amp; Son, Hagerstown, Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>Aug 17 '61</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Haines</b>			

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL or give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>40 YRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>730 SALEM AVE.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM</b> First <b>EDWARD</b> Middle <b>SLOAN</b> Last		4. DATE OF DEATH <b>AUGUST</b> Month <b>27</b> Day <b>19</b> Year <b>61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/8/1888</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED CONDUCTOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RAIL ROAD</b>	
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SAMUEL SLOAN</b>		14. MOTHER'S MAIDEN NAME <b>MARY JANE ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>719-05-6356</b>	
17. INFORMANT <b>MRS. ETHEL I. SLOAN</b>		18. HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intestinal Obstruction</b> <b>153-1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cancer of Transverse Colon</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>none</b> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 30</b> , 19 <b>61</b> , to <b>Aug. 27</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Aug. 26</b> , 19 <b>61</b> , and that death occurred at <b>10A</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Harold R. Tutch Jr.</b>		22b. DATE SIGNED <b>8-28-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Harold R. Tutch, Jr. M.D.</b>		22d. ADDRESS <b>302 N. Potomac Street -Hagerstown, Md</b>	
23a. BURIAL, CREMATION, or other disposal (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>8/30/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b>		23d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Korman</b>		25a. REC'D BY REGISTRAR <b>SEP 1 '61</b>	
ADDRESS <b>Hagerstown, Md.</b>		25b. REGISTRAR'S SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 **MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

9639

09650

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>65 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		e. STREET ADDRESS <u>1153 Kuhn Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Grover</u> Middle <u>Cleveland</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>August</u> Day <u>23</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 23, 1888</u>
9. AGE (In years last birthday) <u>72 yrs.</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Municipal</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Waynesboro, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Smith</u>		14. MOTHER'S MAIDEN NAME <u>Annabelle Burkett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Geo. J. Smith 122 Clarkson Ave. Hagerstown, Md.</u>		Address <u>Hagerstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular insufficiency (CUA)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Advanced arteriosclerosis</u> DUE TO (c) <u>Diabetes Mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>32 hrs.</u> <u>yrs.</u> <u>yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 18, 1961</u> to <u>Aug. 23, 1961</u> , that (I) (we) last saw the deceased alive on <u>Aug. 23, 1961</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Harold R. Tutch Jr.</u>		22b. DATE SIGNED <u>8/23/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Harold R. Tutch Jr. M.D.</u>		22d. ADDRESS <u>302 N. Potomac St. Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/26/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. G. Horst</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 28 '61</u>	
ADDRESS <u>Hagerstown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
9640  
CERTIFICATE OF DEATH

09631

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>16 Yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>122 So Potomac st</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>122 So Potomac st</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>LENA</u>		Middle <u>IMO</u>		Last <u>SMITH</u>		4. DATE OF DEATH Month <u>August</u> Day <u>8</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 20 1880</u>		9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Williamsport Wash Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Christian Fridinger</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Ernede</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>George W.G. Smith 122 So potomac St</u> Address <u>Hagerstown Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage, primary</u> DUE TO (b) <u>Cerebral hemorrhage, 2nd attack</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Arteriosclerotic vascular hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Arteriosclerotic vascular hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH <u>July 21, '61</u> <u>14 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 7, 1961</u> to <u>Aug 5, 1961</u> , that (I) <u>(no)</u> last saw the deceased alive on <u>Aug 5, 1961</u> , and that death occurred at <u>8:30</u> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>J. Walter Layman, M. D.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>100 Professional Arts Bldg.,</u>		22b. DATE SIGNED <u>8/11/1961</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/11/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Wash Co Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown M.d</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 14 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

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Andrew E. Coffman  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
9641  
CERTIFICATE OF DEATH  
09632

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY in 1b <u>20 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u> d. STREET ADDRESS <u>1037 Florida Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Marie</u> Middle <u>Susan</u> Last <u>Sowers</u>		4. DATE OF DEATH Month <u>August</u> Day <u>6</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1909</u> <u>Sept. 16, 1911</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Restaurant Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Food</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Madison County, Va.</u>
13. FATHER'S NAME <u>Jiny Nicholson</u>		14. MOTHER'S MAIDEN NAME <u>Ritte Berry</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-24-7597</u>	
17. INFORMANT <u>Mr. C.D. Sours</u>		Address <u>1037 Florida Ave. Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Artery Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Coronary Arteriosclerotic Heart Disease</u> (c) <u>Diabetic Mellitus - Obesity</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Diabetic Mellitus - Obesity</u>			INTERVAL BETWEEN ONSET AND DEATH <u>20 minutes</u> <u>2 1/2 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3-23</u> 19 <u>60</u> to <u>8-6</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>8-6</u> 19 <u>61</u> , and that death occurred at <u>8 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Salton M. Welly</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Salton M. Welly</u>		22d. ADDRESS <u>Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8/8/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Hagerstown Md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. G. Hook</u>		25a. REC'D BY REGISTRAR <u>AUG 9 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	

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4. *Conclusions*

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 09633

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 8 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington County Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 1515 Mayfair Ave.	
3. NAME OF DECEASED (Type or print) ANNIE E. STOTTLEMYER		4. DATE OF DEATH 8 18 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/11/1890
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Daniel Warrenfeltz		14. MOTHER'S MAIDEN NAME Rebecca Kline	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Fern Stottlemeyer, 515 Mayfair Ave.,		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO 420.0 CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDER- LYING CAUSE LAST. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) GENERALIZED ARTERIOSCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH 20 MINUTES UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus, Hypertensive Cardio-vascular Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 5, 1961, to Aug 18, 1961, that I last saw the deceased alive on Aug 18, 1961, and that death occurred at 3:15 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE E. R. Landigabal		DATE SIGNED 8-19-61	
PHYSICIAN'S NAME (Type) E. R. Landigabal		ADDRESS (Street, city or town, state) 12 South Main Smithsburg, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 8/21/1961	
22c. NAME OF CEMETERY OR CREMATORY U.B. Cemetery		22d. LOCATION (City, town, or county) (State) Wolfsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Md.		24a. REC'D BY REGISTRAR DATE AUG 22 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

NAME OF DECEASED <b>FRANK ST. CLEVELAND</b>		DATE OF BIRTH <b>1900</b>		PLACE OF BIRTH <b>NEW YORK</b>	
SEX <b>MALE</b>		RACE <b>WHITE</b>		EDUCATION <b>HIGH SCHOOL</b>	
OCCUPATION <b>LABORER</b>		MARRIAGE <b>MARRIED</b>		DATE OF MARRIAGE <b>1920</b>	
RESIDENCE <b>1234 E. STREET</b>		CITY <b>BALTIMORE</b>		COUNTY <b>BALTIMORE</b>	
DATE OF DEATH <b>1925</b>		PLACE OF DEATH <b>HOME</b>		CAUSE OF DEATH <b>HEART DISEASE</b>	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY				a. STATE			
WASHINGTON				MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		b. COUNTY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
HAGERSTOWN		20 YEARS		WASHINGTON		HAGERSTOWN	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS			
No. 31 GLENSIDE AVENUE				No. 31 GLENSIDE AVENUE			
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
LIZZIE SETORA STOFFER				AUGUST - 6 - 1961			
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
FEMALE		WHITE		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday)	
						87 yrs.	
						IF UNDER 1 YEAR	
						Months Days Hours Min.	
						9 27	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
HOUSE WIFE				OWN HOME			
11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
BEAVER CREEK WASH. CO. MD.				U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
THOMAS MCKEE				ELIZABETH FAHNEY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.			
NO				NONE			
17. INFORMANT				Address			
WILBUR C. STOFFER				31 GLENSIDE AVE. HAGERSTOWN MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary arteriosclerosis with occlusion				6 days			
420.0 DUE TO (b) Arteriosclerotic heart disease				Indefinite			
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) Hypertensive vascular disease				Indefinite			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
Hour a.m. p.m.		19		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20f. (City or town) (County) (State)	
21. I certify that (u) (this hospital) attended the deceased from 8:30A, 1950, to Aug. 6, 1961 that (u) (we) last saw the deceased alive on July 31, 1961, and that death occurred at M, from the causes and on the date stated above.							
22a. SIGNATURE				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)	
B. B. Kneisley				8/7/61		B. B. Kneisley, M.D.	
22d. ADDRESS				22e. REC'D BY REGISTRAR			
148 West Washington Street Hagerstown, Md.				22f. REGISTRAR'S SIGNATURE			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		AUG. 8. 1961		MANOR CEMETERY		NEAR TILGHMANTON WASH. CO. MD	
24. FUNERAL DIRECTOR'S SIGNATURE				25a. DATE			
John B. Bast				AUG 11 '61			
25b. REGISTRAR'S SIGNATURE				25c. REGISTRAR'S SIGNATURE			
Boonsboro MD.				C. L. Kneisley			

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9643

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Page 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HANCOCK</b> c. LENGTH OF STAY IN 1b <b>49 YEARS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>FULTON STREET</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>X HANCOCK</b> d. STREET ADDRESS <b>FULTON STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>MARY GRANBY UNGER</b>			4. DATE OF DEATH Month <b>8</b> Day <b>31</b> Year <b>19 61</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/18/1878</b>	9. AGE (In years last birthday) <b>83</b> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (County & State, or foreign country) <b>HINCKLE, VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>JOHN HINCKLE</b>		
14. MOTHER'S MAIDEN NAME <b>RUTH MAUZEY</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO.			17. INFORMANT <b>RAYMOND L. UNGER, HANCOCK, MARYLAND</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>153.3</b> DUE TO <b>Gastric and sigmoid colon</b> (b) <b>Cardiovascular hypertensive</b> (c) <b>Hydro nephrosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH: (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 31, 1961</b> to <b>Aug 31, 1961</b> , that (I) <del>last</del> saw the deceased alive on <b>Aug 31, 1961</b> , and that death occurred at <b>10 AM</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>L M SHAFER</b> 22c. PHYSICIAN'S NAME (Type) <b>L M SHAFER</b>			22b. DATE SIGNED <b>Aug 31, 1961</b> 22d. ADDRESS <b>HANCOCK MD</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>9/3/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>TONCLOWAY BAPTIST</b>		23d. LOCATION (City, town or county) (State) <b>FULTON CO., PENNA.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Howard J. Moore</b>			25a. REC'D BY REGISTRAR <b>SEP 6 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>		

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*Government of India  
Ministry of Education  
New Delhi*

*Letter No. 1000/1  
Dated 10/10/51*

*Mr. [Name]  
[Address]  
[City]*

*Enclosed are...*

*Yours faithfully,  
[Signature]*

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director has been signed by the attending physician and completely filled in. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Information from birth cert.

## CERTIFICATE OF DEATH

Reg. Dist. No. 00636

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>03</u> <u>HAGERSTOWN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. COUNTY HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>DUANE ALLEN VAUGHN</u>		4. DATE OF DEATH Month Day Year <u>AUGUST 12 1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUGUST 12 1961</u>
9. AGE (In years last birthday) yrs. <u>1</u> <u>25</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>1</u> <u>25</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>BEVERLY FLAINE VAUGHN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MOTHER</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>7625</u> IMMEDIATE CAUSE (a) <u>Atelectasis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Imaturity</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 Hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour O. P. M. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-12</u> , 19 <u>61</u> , to <u>8-12</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>8-12</u> , 19 <u>61</u> , and that death occurred at <u>7:50 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. J. Woodlee</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>115 King St. Hagerstown, Md. 8-15-61</u>	
PHYSICIAN'S NAME (Type) <u>DR. S. E. WADDILL, HAGERSTOWN, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>AUG. 15, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>WASH. CO. HOSPITAL</u>		22d. LOCATION (City, town, or county) (State) <u>HAGERSTOWN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Aschaffer, Adm. WASH. CO. HOSP.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 18 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Clarence L. Frank</u>			

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9646

## CERTIFICATE OF DEATH

09637

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY in lb <b>most of life</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington County Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>1048 Corbett Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>IGNATIUS</b> Last <b>WAGNER</b>		4. DATE OF DEATH Month <b>August</b> Day <b>13</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 12, 1876</b>
9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR Months <b></b> Days <b></b>	11. IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter, Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Emmitsburg, Maryland</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ignatius Wagner</b>		14. MOTHER'S MAIDEN NAME <b>Mary Livers</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>196-09-1949</b>	
17. INFORMANT <b>Mr. Paul A. Wagner</b>		Address <b>Williamsport, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism - post operative</b> 570.5 DUE TO (b) <b>Partial obstruction ascending colon</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <b></b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>0 Benign prostatic hypertrophy @ gen / arteriosclerosis</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>8-1-1961</b> to <b>8-13-1961</b> , that (I) (we) last saw the deceased alive on <b>8-12-1961</b> , and that death occurred at <b>11:00 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>A. E. W. Little Jr.</b>		22b. DATE SIGNED <b>8-13-1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. E. W. Little Jr.</b>		22d. ADDRESS <b>Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8/16/1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Hagerstown, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. Franklin Meyer</b>		25a. REC'D BY REGISTRAR <b>DATE AUG 17 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9647

## CERTIFICATE OF DEATH

09638

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN Yr <b>58 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington County Hospital</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
3. NAME OF DECEASED (Type or print) First <b>MILDRED</b> Middle <b>SYLVIA</b> Last <b>WIBBERLEY</b>		d. STREET ADDRESS <b>911 Dewey Ave.</b>	
4. DATE OF DEATH Month <b>August</b> Day <b>31</b> Year <b>1961</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 23, 1898</b>
9. AGE (In years last birthday) <b>63 yrs.</b>		IF UNDER 1 YEAR Months <b>03</b> Days <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Chambersburg, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Agustus Seiss</b>		14. MOTHER'S MAIDEN NAME <b>Vesta Burnett</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Louis Olivere</b>		Address <b>Wilmington, Delaware</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Carcinomatous involving Lungs &amp; pelvis</b> DUE TO (b) <b>Th</b> DUE TO (c) <b>Carcinoma Breast</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 mo</b> <b>13 1/2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3-1-61</b> , 19 <b>61</b> , to <b>8-31-61</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>8-30-61</b> , and that death occurred <b>at 4 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>L. E. W. Suter</b>		22b. DATE SIGNED <b>SEP 5 '61</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. E. W. Suter</b>		22d. ADDRESS <b>Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/2/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Hagerstown Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Suter - Rouzer Funeral Home</b>		25a. REC'D BY REGISTRAR <b>SEP 5 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9648

09639

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>1 yr.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>49 W. Bethel St.</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u> d. STREET ADDRESS <u>149 W. Bethel St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Wilkerson</u> First <u>LAST</u> Middle <u>First</u>		<b>4. DATE OF DEATH</b> Month <u>Aug.</u> Day <u>1</u> Year <u>19 61</u>	
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>Colored</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Feb. 18, 1880</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		<b>9. AGE</b> (In years last birthday) <u>81</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> <b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Frederick, Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> <u>Robert Wilkerson</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Lucy Henderson</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>  </u> (If yes, give war or dates of service) <u>  </u>		<b>16. SOCIAL SECURITY NO.</b> <u>  </u>	
<b>17. INFORMANT</b> <u>Fred E. White</u> <u>Route #5 Braddock, Md.</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>My Asthma and Old Chronic Heart Disease</u> 331 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Cerebral Hemorrhage</u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>  </u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20. INTERVAL BETWEEN ONSET AND DEATH</b> <u>1 yr.</u>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, notify medical examiner)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. <u>  </u> p.m. <u>  </u> <u>  </u> 19 <u>  </u>	<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>	<b>20f. (City or town)</b> (County) (State) <u>  </u>
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>June 27, 1961</u> <u>to</u> <u>August 1, 1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>June 27, 1961</u> , <b>and that death occurred at</b> <u>1:30 AM</u> , <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Philip J. Hirshman</u>		<b>22b. DATE SIGNED</b> <u>8/1/61</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Philip J. Hirshman, M.D.</u>		<b>22d. ADDRESS</b> <u>159 W. Washington St.</u> <u>Hagerstown, Maryland</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>23b. DATE THEREOF</b> <u>8/5/61</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Fairview Cem.</u>	<b>23d. LOCATION</b> (City, town or county) (State) <u>Frederick, Maryland</u>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Charles E. Hicks</u>		<b>25a. REC'D BY REGISTRAR</b> <u>AUG 7 '61</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles E. Hicks</u>		<b>25c. REGISTRAR'S SIGNATURE</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

9649

09640

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BOONSBORO</b> c. LENGTH OF STAY IN 1b <b>40 YEARS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>408 N. MAIN ST.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BOONSBORO</b> d. STREET ADDRESS <b>408 N. MAIN ST.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EDITH BELL WISE</b>		4. DATE OF DEATH <b>AUGUST - 8 - 1961</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 23 - 1879</b>
9. AGE (In years last birthday) <b>82 yrs.</b>		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>15</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE KEEPER</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MIDDLE TOWN FRIED. CO. MD. U.S.A.</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13. FATHER'S NAME <b>JOSEPHUS H. WISE</b>	
14. MOTHER'S MAIDEN NAME <b>SUSAN CROSS</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>218-30-7719</b>		17. INFORMANT <b>MISS CLADYS THOMAS BOONSBORO MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardiovascular Disease</b> DUE TO (b) <b>Cerebral Hemorrhage</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs 2 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)	
20h. (State)		21. I certify that (I) (this hospital) attended the deceased from <b>Aug 10, 1960</b> to <b>Aug 8, 1961</b> , that (I) (we) last saw the deceased alive on <b>Aug 7, 1961</b> , and that death occurred at <b>8 A.M.</b> from the causes and on the date stated above.	
22a. SIGNATURE <b>G. W. LeVan M.D.</b>		22b. DATE SIGNED <b>8/9/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>G. W. LeVan</b>		22d. ADDRESS <b>Boonsboro</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>AUG. 11, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>BOONSBORO CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>BOONSBORO WASH. CO. MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John D. Bast</b>		25a. REC'D BY REGISTRAR <b>AUG 11 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles S. Kline</b>		25c. ADDRESS <b>Boonsboro MD</b>	

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